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Supreme Court of the United States
OCTOBER TERM, 1996

METRO-NORTH COMMUTER RAILROAD COMPANY,
Petitioner,
v.
MICHAEL BUCKLEY,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF FOR *AMICI CURIAE* THE CHEMICAL MANUFACTURERS ASSOCIATION AND THE CHAMBER OF COMMERCE OF THE UNITED STATES IN SUPPORT OF PETITIONER

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BRIEF FOR *AMICI CURIAE* THE CHEMICAL MANUFACTURERS ASSOCIATION AND THE CHAMBER OF COMMERCE OF THE UNITED STATES IN SUPPORT OF PETITIONER

INTEREST OF THE *AMICI CURIAE*[1]

The Chemical Manufacturers Association ("CMA") is a non-profit trade association whose members produce, market, and use industrial chemicals. The chemical industry employs over one million workers in this country, and on a value-added basis, it accounts for over ten percent of U.S. manufacturing. The Chamber of Commerce of the United States ("Chamber") is the largest federation of business, trade, and professional organizations in the United States. It represents more than 215,000

[1] Petitioner and respondent have consented to the filing of this brief; letters to that effect have been lodged with the Clerk.

companies, as well as several thousand trade and professional organizations, and state and local chambers of commerce.

The Court of Appeals in this case and a small number of other courts have held that persons who have been exposed to a hazardous substance but have not developed, and probably will never develop, a resulting illness may nevertheless recover the cost of special future medical testing to detect delayed-onset diseases that might conceivably result from the exposure. These courts in effect have invented an entirely new cause of action—the tort of "medical monitoring"—that lacks any historical pedigree and is today recognized in only a handful of jurisdictions.

Industrial companies, including members of the CMA and many members of the Chamber, have long "monitored" the health of their employees who work with hazardous substances, but that activity is quite different from the type of monitoring contemplated by the medical monitoring tort. The point of monitoring in the industrial setting is to ascertain whether workers with ongoing exposure to potentially hazardous substances *currently* suffer any adverse effects of that exposure, and, if so, to reduce their exposure. The medical monitoring tort, by contrast, compensates persons who allegedly face a risk of becoming ill in the distant future because of exposure to a hazardous substance in the past. Monitoring in industry is based on sound principles of medicine and industrial hygiene. The medical monitoring tort rests on assumptions about the benefits of medical testing for asymptomatic persons that have generally been rejected by the medical profession itself.

This Court's recognition of a claim for medical monitoring under the Federal Employers Liability Act (FELA), 45 U.S.C. § 51 *et seq.*, could inundate the judicial system with claims by railroad workers who are not ill as a result of exposure to chemicals and are unlikely ever to become so. Such a ruling would also doubtless influence the

development of common-law tort doctrine in this area.[2] The CMA and the Chamber submit that this Court should reject any interpretation of the FELA that allows persons without manifest injury in the traditional sense to recover the costs of future medical testing.

SUMMARY OF ARGUMENT

There is considerable intuitive appeal to the idea that people who face a risk of future illness would benefit by receiving periodic testing to detect the possible onset of disease. In recent years, however, the medical profession has subjected that intuition to critical scrutiny and has found it for the most part to be unsound. Medical science now recognizes that persons without manifest symptoms of illness ordinarily benefit from only a fairly small number of well-established tests that are recommended for almost everyone. The sort of special testing of asymptomatic persons envisioned by the medical monitoring tort has been found to be generally ineffective. If medical science does not see substantial value in special testing of asymptomatic persons, there is certainly no basis for courts to elevate the claimed "need" of exposed persons for such testing to the status of a legally protected interest.

The medical monitoring tort, if widely accepted, would have staggering implications for the administration of the civil justice system. This new tort opens the courthouse doors to literally millions of would-be claimants who have no demonstrable illness, but who can allege some type of exposure to some substance that may create a risk of future illness. And once inside the courthouse, these

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[2] This Court's interpretations of tort principles, although undertaken in connection with issues of federal law, are often followed by courts confronting similar issues under state law. *See, e.g., Casa Clara Condominium Ass'n* v. *Charley Toppino & Sons*, 620 So. 2d 1244, 1246-47 (Fla. 1993) (following *East River S.S. Corp.* v. *Transamerica Delaval, Inc.*, 476 U.S. 858 (1986)); *Dickerson* v. *International UAW Union*, 648 N.E.2d 40, 50 (Ohio Ct. App. 1994) (following *Consolidated Rail Corp.* v. *Gottshall*, 114 S. Ct. 2396, 2411 (1994)).

claims are not easily screened out, because the medical monitoring tort as courts have so far defined it sets the threshold of a triable claim extremely low and tolerates, indeed invites, highly speculative proof.

ARGUMENT

I. THE MEDICAL MONITORING TORT IS A RADICAL DEPARTURE FROM THE COMMON LAW.

A. The Tort Rests on a Novel Notion of "Injury."

The traditional rule under the common law is that to maintain a cause of action for negligence, a plaintiff must allege that he has sustained either a manifest personal injury (physical harm or, in some circumstances, emotional harm) or damage to property. *See* Patrick S. Atiyah, *Negligence and Economic Loss*, 83 L.Q. REV. 248, 248 (1967) (noting the "general principle denying liability for purely economic loss in the law of negligence"); *see also In re Paoli R.R. Yard PCB Litig.* ("*Paoli I*"), 916 F.2d 829, 850 (3d Cir. 1990) ("traditionally, injury needed to be manifest before it could be compensable"); Susan L. Martin & Jonathan D. Martin, *Tort Actions for Medical Monitoring: Warranted or Wasteful?*, 20 COLUM. J. ENVTL. L. 121, 122 (1995). This was the common-law rule in 1908 when the FELA was enacted. *See* 1 THOMAS ATKINS STREET, THE FOUNDATIONS OF LEGAL LIABILITY 493 (1906) ("it appears that injury is always a prerequisite condition of liability and without injury no right of action can exist").

A corollary of this rule is that a plaintiff may recover the cost of future medical procedures only if he has suffered a manifest personal injury and proves that those future expenses are reasonably certain to be incurred as a result of the injury. This is the traditional rule, *see* CHARLES T. MCCORMICK, HANDBOOK ON THE LAW OF DAMAGES § 90 (1935), and it is the prevailing rule today, *see* JACOB A. STEIN, STEIN ON PERSONAL INJURY DAMAGES § 5.18, at 245-47 (2d ed. 1991) (future medical expenses must be "reasonably certain to become necessary" and "[t]here must be evidence of a continuing or permanent disability and the necessity of future medical treatment of the disability").

In the last fifteen years, however, a small number of courts have abandoned the requirement of manifest injury in "toxic tort" cases. These courts have held that plaintiffs who have been exposed to a hazardous substance but have not experienced—and probably will never experience—a resulting illness are nevertheless entitled to recover the cost of future "medical monitoring" (sometimes denominated "medical surveillance") to facilitate early detection of delayed-onset diseases for which they allegedly have been placed at increased risk because of the exposure. *See, e.g., Paoli I*, 916 F.2d at 852; *Ayers* v. *Township of Jackson*, 525 A.2d 287, 312 (N.J. 1987); *Potter* v. *Firestone Tire & Rubber Co.*, 25 Cal. Rptr. 2d 550, 579-80 (1993); *Hansen* v. *Mountain Fuel Supply Co.*, 858 P.2d 970, 975-82 (Utah 1993). Typically the diseases of concern are various forms of cancer. *See Ayers*, 525 A.2d at 311. Because cancers usually occur later in life, the risk of cancer is thought to require lifetime, or at least very long-term, medical monitoring. *See id.* at 313 n.13 (plaintiffs awarded damages to cover lifetime medical monitoring).

Some courts, including the Court of Appeals in the present case, seemingly base the plaintiff's entitlement to medical monitoring on a theoretical construction of the notion of physical "injury." These courts hold that exposure to a hazardous substance, in itself, constitutes a physical injury, and so under traditional tort principles one who has been exposed because of the defendant's negligence may recover the full range of damages flowing from the injury, including the cost of future medical monitoring procedures allegedly necessitated by the exposure. *See Buckley* v. *Metro-North Commuter R.R.*, 79 F.3d 1337, 1343-45, 1347 (2d Cir.), *cert. granted*, 117 S. Ct. 379 (1996); *Askey* v. *Occidental Chem. Corp.*, 477 N.Y.S.2d 242, 246-47 (App. Div. 1984).

More commonly, though, courts that have allowed recovery for medical monitoring have not attempted to shoehorn the claim into the conventional definition of "injury." Instead, they have dispensed with the requirement altogether to create what they acknowledge is a "non-traditional," independent tort. *E.g., Paoli I*, 916 F.2d at 849; *Cook* v. *Rockwell Int'l Corp.*, 755 F. Supp. 1468, 1476 (D. Colo. 1991). These courts hold that the plaintiff's need to incur the cost of future medical monitoring procedures as a result of an alleged chemical exposure is itself an actionable injury. *E.g., Paoli I*, 916 F.2d at 851-52; *Cook*, 755 F. Supp. at 1477; *Meyerhoff* v. *Turner Constr. Co.*, 534 N.W.2d 204, 206 (Mich. Ct. App. 1995), *appeal denied*, 550 N.W.2d 538 (Mich. 1996); *Hansen*, 858 P.2d at 977. The Second Circuit in this case approvingly cited decisions that have recognized claims for medical monitoring on this basis. *See* 79 F.3d at 1347.

Although the courts have offered slightly varying statements of the medical monitoring tort, one widely cited formulation holds that a plaintiff must prove the following elements:

> 1. Plaintiff was significantly exposed to a proven hazardous substance through the negligent actions of the defendant.
>
> 2. As a proximate result of exposure, plaintiff suffers a significantly increased risk of contracting a serious latent disease.
>
> 3. That increased risk makes periodic diagnostic medical examinations reasonably necessary.
>
> 4. Monitoring and testing procedures exist which make the early detection and treatment of the disease possible and beneficial.

Paoli I, 916 F.2d at 852. The *Paoli I* "definition is generally in accord with how other courts have characterized medical monitoring claims." *Building & Constr. Dep't* v. *Rockwell Int'l Corp.*, 7 F.3d 1487, 1493 (10th

Cir. 1993). The medical monitoring tort compensates exposed persons only for "special" medical testing made necessary by the exposure, that is, testing beyond what would be necessary or appropriate even without the exposure. *See In re Paoli R.R. Yard PCB Litig.* (*"Paoli II"*), 35 F.3d 717, 788 (3d Cir. 1994), *cert. denied*, 115 S. Ct. 1253 (1995); *Hansen*, 858 P.2d at 980. To make out a claim for such special testing, however, a plaintiff need not prove that he will in fact contract a disease caused by the exposure, nor even that his developing such a disease in the future is more probable than not. *Ayers*, 525 A.2d at 309. A "significant" risk of future disease, as courts have defined it, can be very small. *See infra* at 23.

Even as they acknowledge the novelty of the medical monitoring tort, courts that have recognized the claim have sought to downplay the extent of its departure from traditional tort principles. Typical is the reasoning of one court:

> A plaintiff who is involved in an automobile accident and suffers no observable physical injury but nevertheless undergoes medically necessary diagnostic tests to determine whether internal injuries exist is no doubt entitled to recover the costs of the examination. . . . The outcome should be the same when the operative incident is toxic exposure rather than collision.

Miranda v. *Shell Oil Co.*, 7 Cal. Rptr. 2d 623, 626 (Cal. Ct. App. 1992). But the analogy drawn by this passage is flawed in two respects. First, the plaintiff who is involved in an automobile collision does in fact sustain physical "injury" in a traditional sense—a traumatic force to the body—even if the injury is not "observable" after the fact or is too insignificant to warrant compensation. *See, e.g., Homans* v. *Boston Elevated Ry. Co.*, 62 N.E. 737 (Mass. 1902). The introduction of unwanted chemicals into the human body is not a physical injury in any familiar sense. *See, e.g., Schweitzer* v. *Consolidated Rail*

Corp., 758 F.2d 936, 942 (3d Cir. 1985). If chemical exposure is an injury, then almost every person in industrialized society is injured on a daily basis. *See infra* at 21-22. A second flaw in the analogy is that the automobile accident victim recovers only for testing expenses *actually incurred* to ascertain the extent of then-existing damage, if any, from the traumatic force. *See, e.g.*, *Newsom* v. *Markus*, 588 S.W.2d 883, 887-88 (Tenn. Ct. App. 1979). The medical monitoring tort, by contrast, compensates plaintiffs for the costs of long-term *future* medical testing to diagnose injuries that do not yet exist and probably will never develop.

B. The Medical Monitoring Tort Has Been Recognized in Only a Small Minority of Jurisdictions.

In FELA cases, this Court "look[s] to the common law when considering the right to recover asserted" by the plaintiff. *Consolidated Rail Corp.* v. *Gottshall*, 114 S. Ct. 2396, 2411 (1994). To the extent that the point of reference is the common law in 1908, when the FELA was enacted, the medical monitoring tort finds no support. In 1908, courts in this country required some manifest physical or emotional injury as a prerequisite of a negligence action, *see* THOMAS ATKINS STREET, *supra*, at 493, as indeed they did for many years thereafter. A claim for "medical monitoring" was not mentioned in a reported decision until the late 1970s, and no appellate court appears to have recognized the medical monitoring tort until the 1984 decision of the New York Supreme Court Appellate Division in *Askey*, 477 N.Y.S.2d at 242. *See* George W.C. McCarter, *Medical Sue-veillance: A History and Critique of the Medical Monitoring Remedy in Toxic Tort Litigation*, 45 RUTGERS L. REV. 227, 231-42 (1993) (tracing the early history of the tort); *cf. Gottshall*, 114 S. Ct. at 2411 ("relative bystander" test of negligent infliction of emotional distress "was not developed until 60 years after FELA's enactment, and therefore lacks historical support").

Today the medical monitoring tort has been recognized in only a small minority of jurisdictions. In only three states—New Jersey, California, and Utah—has the highest state court recognized it. *See Ayers*, 525 A.2d at 297-313; *Potter*, 25 Cal. Rptr. 2d 550, 579-80; *Hansen*, 858 P.2d at 975-82.[3] And the Supreme Court of New Jersey, after broadly embracing the tort in *Ayers*, has since sharply limited its availability. That court now holds that the claim "is not easily invoked," and may be pursued only by persons who have experienced "direct[]" exposure to a hazardous substance or have suffered a physical injury as a result of the exposure. *Theer* v. *Philip Carey Co.*, 628 A.2d 724, 733 (N.J. 1993).

In three other states—Arizona, Michigan, and New York—medical monitoring claims have been recognized by intermediate appellate courts. *See Burns* v. *Jaquays Mining Corp.*, 752 P.2d 28, 33-34 (Ariz. Ct. App. 1987); *Meyerhoff*, 534 N.W.2d at 206; *Askey*, 477 N.Y.S.2d at 246-47 (dictum). Elsewhere the courts that have "recognized" this new tort have been federal courts sitting in diversity, which have ventured predictions of state law in the absence of any controlling authority. *See Cook*, 755 F. Supp. at 1476-77 (Colorado law); *Woodman* v. *United States*, 1995 U.S. Dist. LEXIS 2787, at *121-22 (M.D. Fla. Jan. 24, 1995) (Florida law); *Bocoock* v. *Ashland Oil, Inc.*, 819 F. Supp. 530 (S.D. W. Va. 1993)

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[3] The Supreme Court of Pennsylvania has held that medical monitoring expenses may be recovered by persons who have suffered pleural thickening as a result of asbestos exposure. *Simmons* v. *Pacor, Inc.*, 674 A.2d 232, 239-40 (Pa. 1996). Although *Simmons* held that pleural thickening is not a sufficient "injury" to support recovery for mental anguish because the condition is not accompanied by "disabling consequences or physical impairment," *id.* at 236, 238, pleural thickening is a clinically identifiable physical consequence of asbestos exposure. *See Fried* v. *Sungard Recovery Servs.*, 936 F. Supp. 310, 311 (E.D. Pa. 1996) (plaintiffs with no physical manifestations of exposure may not recover for medical monitoring because *Simmons* requires proof of "demonstrable physical consequences" caused by exposure).

(Kentucky law); *Gibbs* v. *E.I. DuPont de Nemours & Co.*, 876 F. Supp. 475, 477-79 (W.D.N.Y. 1995) (New York law); *Day* v. *NLO, Inc.*, 851 F. Supp. 869, 879-82 (S.D. Ohio 1994) (Ohio law); *Paoli I*, 916 F.2d at 849-52 (Pennsylvania law).[4] These forecasts of state law are at best an uncertain gauge of the common law's current attitude on the matter, because federal courts' predictions of state law are "not binding on state courts and may be discredited at any time." *Moore* v. *Sims*, 442 U.S. 415, 428 (1979); *cf. Paoli II*, 35 F.3d at 786 (noting that intervening Pennsylvania decisions had "cast[] some doubt" on the prediction ventured in *Paoli I*).

There is by no means an obvious trend toward acceptance of the medical monitoring tort. A number of courts have considered and explicitly rejected the claim. These

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[4] Certain other courts have used the term "medical monitoring" in connection with requests for future medical expenses by plaintiffs who have allegedly sustained a physical injury as a result of chemical exposure. *See, e.g., Hagerty* v. *L&L Marine Servs., Inc.*, 788 F.2d 315, 319 (5th Cir. 1986) (plaintiff had "[d]izziness, leg cramps, and a persistent stinging sensation in feet and fingers"); *Burton* v. *R.J. Reynolds Tobacco Co.*, 884 F. Supp. 1515, 1522-23 (D. Kan. 1995) (plaintiff had peripheral vascular disease). In upholding such requests, these courts have applied traditional damages principles, *see id.* at 1523, and have not endorsed a free-standing medical monitoring tort.

Friends for All Children, Inc. v. *Lockheed Aircraft Corp.*, 746 F.2d 816 (D.C. Cir. 1984), is sometimes cited, erroneously, as a progenitor of the medical monitoring tort. *See, e.g., Paoli I*, 916 F.2d at 851; *Ayers*, 525 A.2d at 309-10. In *Friends for All Children* the plaintiffs had been on board an aircraft when it experienced an explosive decompression and crashed, and they all claimed to have a *then-existing* neurological injury as a result of the incident. 746 F.2d at 819. The defendant conceded liability for all compensatory damages. *Id.* at 822. The trial court issued, and the D.C. Circuit affirmed, an injunction *pendente lite* requiring the defendant to fund *one-time* diagnostic examinations of certain plaintiffs to determine whether they were *at that time* in fact suffering from the neurological injuries they claimed. *Id.* at 822, 828. In essence, the plaintiffs were in the position of the automobile-accident victim in the illustration discussed *supra* at 7-8.

courts hold, following the traditional common law rule, that persons who have been exposed to a hazardous substance may recover for future medical testing only if the exposure has caused a physical injury. *See Mergenthaler* v. *Asbestos Corp. of Am.*, 480 A.2d 647, 651 (Del. 1984); *Hayes* v. *AC&S, Inc.*, No. 95 CH 1835, slip op. at 12-14 (Cir. Ct. Cook Cty. Ill. Oct. 30, 1996); *Thomas* v. *FAG Bearings Corp.*, 846 F. Supp. 1400, 1410 (W.D. Mo. 1994) (Missouri law); *Carroll* v. *Litton Sys. Inc.*, 1990 U.S. Dist. LEXIS 16833, at *148-53 (W.D.N.C. Oct. 29, 1990) (magistrate's report and recommendation) (North Carolina law); *Purjet* v. *Hess Oil Virgin Islands Corp.*, 1986 WL 1200, at *4 (D.V.I. Jan. 8, 1986) (Virgin Islands law); *Ball* v. *Joy Techs., Inc.*, 958 F.2d 36, 39 (4th Cir. 1991) (Virginia and West Virginia law).

II. THE MEDICAL COMMUNITY HAS REACHED A CONSENSUS THAT DIAGNOSTIC TESTING OF ASYMPTOMATIC PERSONS IS APPROPRIATE ONLY IN WELL-DEFINED SITUATIONS.

Whether a certain type of alleged detriment should be recognized as a legally cognizable "injury" is not an issue of fact to be determined case by case, but a question of law and policy for the courts. *See Gottshall*, 114 S. Ct. at 2403. The answer depends in large part on whether there is an expert consensus that the particular interest asserted is important enough to warrant society's protection. Recognition of infliction of emotional distress as an independently actionable tort, for instance, was prompted by the conclusion of medical science "that not only fright and shock, but also anxiety, grief, rage and shame, are in themselves 'physical' injuries, producing well marked changes in the body, and symptoms of major importance which are readily visible to the professional eye." William L. Prosser, *Intentional Infliction of Mental Suffering: A New Tort*, 37 MICH. L. REV. 874, 876 (1939). On the other hand, in the absence of widespread agreement that they should be protected, "[t]here are some interests to which the law simply has not extended protection from

injury." 3 FOWLER V. HARPER ET AL., THE LAW OF TORTS § 18.3, at 671 (2d ed. 1986).

In holding that the need to incur the cost of special future medical testing is itself an "injury" deserving of legal protection, courts that have recognized the medical monitoring tort have simply assumed that there is a strong social interest in seeing that exposed persons who display no signs of illness receive special medical testing to detect the possible presence of latent disease. The Supreme Court of New Jersey, for example, has declared that "[t]he value of early diagnosis and treatment for cancer patients is well-documented," citing nothing but the opinion of a member of that court in another case. *Ayers*, 525 A.2d at 311 (citing *Evers* v. *Dollinger*, 471 A.2d 405, 418-19 (N.J. 1984) (Handler, J., concurring)); *see also Askey*, 477 N.Y.S.2d at 247 ("[t]here is no doubt that [medical monitoring] would permit the early detection and treatment of maladies"); *Miranda*, 7 Cal. Rptr. 2d at 627 ("[i]t is common knowledge [that] early diagnosis of many serious conditions promotes enhanced cure and survival rates")

Intuition, it is true, has long told us that going to the doctor is a good thing, and that healthy people should routinely undergo medical testing and examination to facilitate the early detection of a wide variety of latent diseases, especially cancers. For many years that intuition was shared by medical practitioners and lay people alike. *See* Stanley Joel Reiser, *The Emergence of the Concept of Screening for Disease*, 56 MILBANK MEMORIAL FUND *Q./* HEALTH & SOC'Y 403, 406-17 (1978). But in recent years physicians have come to recognize that diagnostic testing, like any other medical intervention, is not good for the patient unless the likely benefits outweigh the risks. Medical science has developed a sophisticated and well-accepted methodology for assessing the medical risks and benefits of diagnostic tests, and the application of that methodology has made clear that our intuition about the desirability of diagnostic testing is generally incorrect.

The medical community now recognizes that, while diagnostic testing makes sense for patients *with symptoms* of disease, such testing is generally not beneficial when applied to persons who do *not* have symptoms of illness. Thus, at the same time that courts have deemed the benefits of extensive medical monitoring to be too obvious to require detailed explanation, medical science after extensive study has come to precisely the opposite conclusion—apart from a small number of well-established testing procedures that are recommended for almost everyone of a given age, the testing of asymptomatic persons to detect latent disease rarely improves outcomes, can be harmful, and is usually not justified. This is true even for those who face a substantially increased risk of disease, such as workers at risk of cancer because of occupational exposure to carcinogens. *See infra* at 17. No court that has recognized the medical monitoring tort has acknowledged, let alone examined, the teachings of modern medical science on this issue.

The consensus view of the medical community on the subject is reflected in the work of the U.S. Preventive Services Task Force ("Task Force"). The United States Public Health Service commissioned the Task Force in 1984, and reconstituted it in 1990, to "develop[] recommendations for clinicians on the appropriate use of preventive interventions, based on a systematic review of evidence of clinical effectiveness." U.S. PREVENTIVE SERVICES TASK FORCE, GUIDE TO CLINICAL PREVENTIVE SERVICES xxviii (2d ed. 1996) ("TASK FORCE GUIDE"). The Task Force has focused in particular on the effectiveness of what physicians refer to as "screening tests"—various tests and procedures that can be administered to asymptomatic persons in an effort to identify those with disease requiring special intervention. Its recommendations have been formulated in cooperation with a number of other health-care organizations, including the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, the Centers for Disease Control, and the National Institutes

of Health. *Id.* at liii. More than 700 experts reviewed the Task Force's recommendations before their publication. *Id.* at liv.

The Task Force's methodological point of departure is this:

> [A] screening test must satisfy two major requirements to be considered effective:
>
> - The test must be able to detect the target condition earlier than without screening and with sufficient accuracy to avoid producing large numbers of false-positive and false-negative results . . . .
> - Screening for and treating persons with early disease should improve the likelihood of favorable health outcomes . . . compared to treating patients when they present with signs or symptoms of disease.

Id. at xlii.

No screening test is accurate in all cases. *See id.* at xliii-xliv. Inaccuracies generally result not from faulty administration of the test by medical personnel but from the inherent difficulty of defining on a generalized basis what constitutes an "abnormal" test result. Philip Cole & Alan S. Morrison, *Basic Issues in Population Screening for Cancer*, 64 J. NAT'L CANCER INST. 1263, 1266 (1980) (noting crucial role of the "criterion of positivity"). The error rates of some screening tests are quite high. In some clinical trials, chest x-rays have been able to identify only 40% to 50% of lung cancers present; that is, at least half the tests yielded false negative results. TASK FORCE GUIDE at 136. Mammography and clinical breast examination to detect breast cancer, though recommended for women over 50, *id.* at 73, have been found to yield false positive results in up to 17% of patients. *Id.* at 74-75. In an asymptomatic population, very few test subjects will actually have the target disease, so the vast majority of

positive test results obtained will be false positives rather than true positives. *Id.* at xliv.[5]

In addition, there are distinct risks associated with inaccurate test results. *See* A.B. Miller, *The Ethics, the Risks and the Benefits of Screening*, 42 BIOMEDICINE & PHARMACOTHERAPY 439, 440-41 (1988); William Feldman, *How Serious Are the Adverse Effects of Screening?*, 5 J. GEN. INTERNAL MED. S50 (1990). Patients who receive test results falsely indicating the absence of disease might develop a misplaced sense of security and delay in seeking medical care when symptoms of the disease later manifest themselves. TASK FORCE GUIDE at xliii. False positive results can lead to more invasive follow-up testing that may be uncomfortable and potentially harmful, for example, coronary angiography after a positive screening test for coronary artery disease. *Id.* at xliv, 5-6. Such results can also "label" as diseased persons who are in fact healthy, causing them to suffer anxiety and other difficulties. *Id.* at xliv, 6; *see also* William Feldman, *supra*, at S51-S52.

Even if a test is reasonably accurate in finding disease before it becomes symptomatic, the sobering reality is that—contrary to the assumptions of some courts—for a great many diseases, including many cancers, early

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[5] The Task Force provides this illustration: In a population of 100,000 in which the prevalence of a cancer is 1%, there would be 1,000 persons with cancer and 99,000 without cancer. A screening test that yields 10% false positives and 10% false negatives would detect 900 of the 1,000 cases of the disease, but it would also mislabel 9,900 healthy persons as having cancer. The proportion of persons with positive test results who actually had cancer—the "positive predictive value" of the test—would be only 8.3%. *Id.* at xliv.

This illustration shows why screening tests are much more effective when applied to persons who display symptoms consistent with the target disease than when applied to an asymptomatic group. In a symptomatic population, the prevalance of the disease is much higher, and so the positive predictive value of the test is higher as well.

detection does *not* improve clinical outcomes.[6] *See, e.g.*, TASK FORCE GUIDE at 6 ("there is little evidence that routine screening is an effective means to reduce the incidence of acute coronary events in asymptomatic persons"); *id.* at 123 ("there is currently no evidence that screening for prostate cancer results in reduced morbidity or mortality"); *id.* at 143-44 (no studies indicate that skin cancers discovered by screening have a better outcome than those which present clinically); *id.* at 170 (there is a "lack of evidence for improved outcome with early detection of pancreatic cancer"); *id.* at 188 ("[t]he benefits of early detection of thyroid cancer in the general population are not well defined"); *see also* Philip Cole & Alan S. Morrison, *supra,* at 1263 (notwithstanding the "compelling intuitive appeal of the idea that detection of early cancer will be rewarding," in fact "the difficulty of trying to improve a population's health by screening is immense"); Thomas M. Gill & Ralph I. Horowitz, *Evaluating the Efficacy of Cancer Screening: Clinical Distinctions and Case-Control Studies,* 48 J. CLINICAL EPIDEMIOLOGY 281, 290 (1995) ("the benefits of screening for most cancers have not been convincingly demonstrated with experimental evidence"). In some cases, screening does not improve outcomes because treatment of the target condition in an asymptomatic state is no more effective than treatment after symptoms have become apparent. In other cases, the unfortunate fact is that no effective treatment is available regardless of when the

[6] Data suggesting that screening prolongs the life expectancy of persons in whom disease is detected must be viewed with caution because such data are easily influenced by "lead-time bias": "survival can appear to be lengthened when screening simply advances earlier the time of diagnosis, lengthening the period of time between diagnosis and death without any true prolongation of life." TASK FORCE GUIDE at xlv. In addition, data can be undermined by "length bias," the tendency of screening to detect a disproportionate number of cases of slowly progressing disease and to miss more virulent, fast-moving cases that are present in the population only briefly. *Id.*

disease is detected. Philip Cole & Alan S. Morrison, *supra,* at 1264 ("There is no point in screening for a disease that can be treated successfully after symptoms appear, nor is it reasonable to screen for an untreatable disease."); TASK FORCE GUIDE at xliv-xlvi.[7]

No disease better illustrates the limitations of screening than lung cancer. In several broad-based studies, researchers have found that mortality does not differ between populations that undergo screening and those that do not. TASK FORCE GUIDE at 136-37. Even persons with a substantially increased risk of lung cancer because of exposure to carcinogens in the workplace have not been found to benefit from such screening. "[B]enefit can only be demonstrated if there is a change in mortality. In neither the general population nor in workers with occupational exposures has such benefit been documented." Anthony A. Marfin & Marc Schenker, *Screening for Lung Cancer: Effective Tests Awaiting Effective Treatment,* 6 OCCUPATIONAL MED.: STATE OF THE ART REVIEWS 111, 129 (1991).

The conclusions of the Task Force stand in stark contrast to the enthusiastic views of diagnostic testing that have been offered by courts in embracing the medical monitoring tort. After a comprehensive review of the medical evidence, the Task Force has identified only a handful of screening procedures for which there is persuasive evidence of clinical effectiveness in asymptomatic

[7] Some physicians find benefit in certain screening procedures for reasons that have little to do with the early detection of disease. For example, many practitioners conduct routine physical examinations of their asymptomatic patients because "examining a patient conveys a special sense of caring," helps establish a relationship of "friendship and trust" between doctor and patient, and provides reassurance to anxious patients. Sylvia K. Oboler & F. Marc LaForce, *The Periodic Physical Examination in Asymptomatic Adults,* 110 ANNALS INTERNAL MED. 214, 215 (1989).

patients.[8] Most of these procedures are recommended for all persons within broad age-based categories. TASK FORCE GUIDE at lxii-lxviii.[9] In addition, the Task Force recommends a small number of screening tests for certain high-risk populations (*e.g.*, an HIV test for persons who inject drugs). *Id.* at lxvi.

But for the vast majority of screening tests—including virtually all such tests intended to facilitate the early detection of latent cancers—the Task Force has found either insufficient evidence of effectiveness or affirmative evidence that the procedures are ineffective or even harmful. These include colonoscopy to detect colorectal cancer, *id.* at 98; screening for pancreatic cancer, *id.* at 171; screening for oral cancer, *id.* at 178; urine cytology or other screening tests to detect bladder cancer, *id.* at 184; screening for thyroid cancer, *id.* at 189-90; and electrocardiography to detect asymptomatic coronary artery disease, *id.* at 10. For the cancer that respondent is said to be at special risk of because of his asbestos exposure—lung cancer—the Task Force recommends against the administration of screening tests to asymptomatic persons. *Id.* at 138.[10]

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[8] The Task Force has *not* taken into account the financial cost of the procedures, TASK FORCE GUIDE at lxxxv, although it recognizes that cost may be a factor in clinical decisions, *id.* at li, lxxxv-xcii.

[9] For example, for persons between the ages of 25 and 64, the Task Force recommends measurement of height, weight, and blood pressure; testing of total blood cholesterol for men over 35 and women over 45; a Papanicolaou test for women; fecal occult blood test or sigmoidoscopy for persons over 50; a mammogram for women over 50; an assessment for problem drinking; and Rubella serology for women of childbearing age. *Id.* at lxvi. In addition, the Task Force recommends that the physician administer certain immunizations and chemoprophylaxis and counsel the patient regarding substance use, diet and exercise, injury prevention, sexual behavior, and dental health. *Id.*

[10] The Task Force assigns screening for lung cancer a "D" recommendation, *id.* at 138, which means there is "fair evidence to

Other medical organizations that have studied the matter have reached essentially the same conclusion as the Task Force—the great majority of available screening tests have not been shown to benefit asymptomatic patients. *See, e.g.*, American College of Physicians, *Periodic Health Examination: A Guide for Designing Individualized Preventive Health Care in Asymptomatic Patients*, 95 ANN. INTERNAL MED. 729 (1981); Canadian Task Force on the Periodic Health Examination, *The Periodic Health Examination*, 121 CANADIAN MED. ASS'N J. 1193 (1979); Robert S.A. Hayward et al., *Preventive Care Guidelines: 1991*, 114 ANN. INTERN. MED. 758 (1991) (comparing the conclusions of the Task Force, the American College of Physicians, the Canadian Task Force on the Periodic Health Examination, and the American Cancer Society).

Given the consensus in the medical profession that asymptomatic persons generally benefit only from certain screening tests that are recommended for virtually everyone, the law should not enshrine as an injury worthy of legal protection the supposed "need" of chemically exposed plaintiffs without any manifest illness to undergo special screening beyond what they should receive in any event. The entitlement to special medical monitoring does not remotely enjoy the same status as the personal interests that the law of negligence has traditionally deemed deserving of protection, namely, freedom from bodily and emotional harm. That the law should protect these interests and compensate their negligent invasion in at least some situations is a matter of universal agreement in our society. By contrast, the desirability of special medical screening to detect latent disease in uninjured persons is not simply controversial—it has been generally

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support the recommendation that the condition be excluded from consideration in a periodic health examination," *id.* at 861.

rejected by the very profession to which society traditionally looks for guidance on such matters.[11]

III. THE MEDICAL MONITORING TORT INVITES ENORMOUS NUMBERS OF SPECULATIVE CLAIMS.

Courts that have embraced the medical monitoring tort have in effect rejected the manifest injury requirement as an arbitrary barrier to the compensation of chemically exposed plaintiffs and the deterrence of activities that give rise to such exposure. *See, e.g., Paoli I,* 916 F.2d at 852; *Ayers,* 525 A.2d at 312. But as this Court has noted,

> "characterizing a rule limiting liability as 'unprincipled' or 'arbitrary' is often the result of overemphasizing the policy considerations favoring imposition of liability, while at the same time failing to acknowledge any countervailing policies."

Gottshall, 114 S. Ct. at 2411 (quoting *Cameron* v. *Pepin,* 610 A.2d 279, 283 (Me. 1992)). The policies of compensating plaintiffs and deterring alleged wrongdoing almost always favor the imposition of liability. Courts that have recognized a cause of action for medical monitoring have focused on these pro-liabiilty policies while ignoring or trivializing the considerations that counsel against recognition of this new tort.

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[11] It is no answer to say that some experts, apparently including those who testified for respondent at trial, dissent from the medical consensus on screening for latent disease, and that disputes over a plaintiff's need for such screening should be resolved by the factfinder. The law does not abdicate to individual factfinders the task of defining what constitutes a legally cognizable injury. "Injury" must be defined by the law on a categorical basis. *See Gottshall,* 114 S. Ct. at 2403. Only if a plaintiff's alleged loss satisfies the legal definition of injury does the claim qualify for submission to the factfinder.

A. The Medical Monitoring Tort Gives a Colorable Claim to a Huge New Class of Potential Plaintiffs.

In eliminating the physical injury requirement, the medical monitoring tort bestows a cause of action, virtually immune from summary disposition, on an enormous new class of potential plaintiffs who are not ill and who almost surely will never become ill as a result of the conduct complained of. This at a time when the volume of *conventional* tort claims concerning just one category of hazardous substance, asbestos, has already "burdened the dockets of many state and federal courts, and has particularly challenged the capacity of the federal judicial system." *Georgine* v. *Amchem Prods.,* 83 F.3d 610, 617 (3d Cir.), *cert. granted,* 117 S. Ct. 379 (1996).

Potentially toxic substances are ubiquitous in American society. As of June 1993, the United States Environmental Protection Agency had identified 37,921 potential hazardous waste sites across the nation. U.S. COUNCIL ON ENVIRONMENTAL QUALITY, TWENTY-FOURTH ANNUAL REPORT 293 (1993). During 1993, an estimated 59 million people lived in counties where air pollution levels failed to meet at least one federally mandated air quality standard. *Id.* at 15. Most foods contain pesticide residues. *Id.* at 307. There is probably no work site in the country where potentially hazardous substances are not present, whether in raw materials used in industrial processes, solvents used to clean machinery, pesticides used in agriculture, or the toner used in office photocopying equipment. Many of these substances are transported by rail at some point in the distribution process.

The hazardous substance involved in this case, asbestos, is ubiquitous in ambient urban air. "The air of cities other than that in the vicinity of asbestos processing plants has . . . been found to carry small amounts of asbestos." IRVING J. SELIKOFF & DOUGLAS H.K. LEE, ASBESTOS AND DISEASE 118 (1978). Diesel exhaust, to note just one other substance that is pervasive in the

environment and in the railroad workplace, is also an alleged toxin. *See, e.g., Kichline* v. *Consolidated Rail Corp.*, 800 F.2d 356, 357 (3d Cir. 1986). Modern analytical techniques are able to detect measurable amounts of countless other potentially hazardous substances in the environment and in human bodies.

It is thus no exaggeration to say that most residents of the United States, and probably all railroad workers, are plausible potential medical monitoring plaintiffs. There can be "little doubt that millions of people have suffered exposure to hazardous substances." *Ball* v. *Joy Mfg. Co.*, 755 F. Supp. 1344, 1372 (S.D. W. Va. 1990), *aff'd*, 958 F.2d 36, 39 (4th Cir. 1991). On a traditional personal injury claim, the threshold requirement of physical injury or illness sharply limits the universe of potential plaintiffs who can go on to try to prove the defendant's negligence and their entitlement to relief. The nominal threshold requirement erected by the medical monitoring tort—exposure to a hazardous substance—scarcely limits the class of potential plaintiffs at all. Almost everyone who lives in industrial society has been exposed, in some amount, to toxic chemicals. The medical monitoring tort makes all such persons eligible to come to court.

Courts that have recognized the medical monitoring tort have responded to concerns about a potential torrent of claims, if at all, by suggesting that such a result will be prevented by the requirement that plaintiffs prove elements in addition to mere exposure. *See Potter*, 25 Cal. Rptr. 2d at 580; *Miranda*, 7 Cal. Rptr. 2d at 628. This response ignores what happens when medical monitoring claims are actually litigated. Nowadays, "[i]t has become fashionable to add a cause of action for medical monitoring to every mass tort complaint." PAUL D. RHEINGOLD, MASS TORT LITIGATION § 12.2, at 12-2 (1996). Moreover, most courts have read the elements of the tort to impose only the most minimal evidentiary burden on plaintiffs. Unless plaintiffs concede, or have a complete failure of proof on, one of the elements, *e.g.*,

Redland Soccer Club, Inc. v. *Department of Army*, 55 F.3d 827, 848 (3d Cir. 1995), *cert. denied*, 116 S. Ct. 772 (1996), medical monitoring claims are almost invulnerable to summary judgment.[12] *See* PAUL D. RHEINGOLD, *supra*, § 12.2, at 12-3. Thus, courts rarely can screen out insubstantial claims as a matter of law.

The elements of "significant" exposure and "significantly increased" risk do not require plaintiffs to quantify the extent of their exposure or the degree of increased risk of disease, even in approximate terms. *Paoli II*, 35 F.3d at 788; *Ayers*, 525 A.2d at 309. The requirement of significant exposure has been found to be satisfied by testimony from the plaintiffs that they were present near soil containing a hazardous substance. *Paoli II*, 35 F.3d at 793. It is not even necessary for plaintiffs to demonstrate that toxins were on the *surface* of the soil. It has been found sufficient that the chemicals were detected below the surface and "could" have migrated upward to the surface. *Redland Soccer*, 55 F.3d at 827. Where plaintiffs have offered quantitative estimates of their increased risk caused by an alleged exposure, it has been held that an increased lifetime cancer risk of just 1 in 100,000, *Paoli II*, 35 F.3d at 794, or even as little as 1 in 1,000,000, *Redland Soccer*, 55 F.3d at 847, is enough to qualify as "significant."[13]

Even if the medical monitoring tort were made available only to persons like respondent who have allegedly

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[12] *But see Abuan* v. *General Elec. Co.*, 3 F.3d 329, 334 (9th Cir. 1993) (holding that plaintiffs failed to create a genuine issue of fact because their experts could not "state how 'significant' or relative the increased risk was for any individual"), *cert. denied*, 510 U.S. 1116 (1994). The Ninth Circuit's approach in *Abuan* has been rejected by the Third Circuit in an influential opinion. *See Paoli II*, 35 F.3d at 788.

[13] In the general population, the lifetime risk that a person will develop cancer is one in two for men and one in three for women. AMERICAN CANCER SOC'Y, CANCER FACTS & FIGURES—1996 at 1. Thus, that a chemical exposure increases a man's risk of cancer by 1 in 1,000,000 means that the risk moves from 50% to 50.0001%.

experienced "massive" exposure to a hazardous substance, *Buckley*, 79 F.3d at 1343, courts would still have no discernible basis for distinguishing "massive" exposures from lesser exposures as a matter of law. The same is true of any attempt to constrain the scope of the tort simply by adding adverbial or adjectival qualifiers to the description of what plaintiffs need to prove. So long as the difference between a compensable claim and a baseless one is a matter of degree, virtually all claims will qualify for submission to the factfinder. *Cf. Gottshall*, 114 S. Ct. at 2409 ("The Third Circuit did require that the emotional injury be 'reasonably' foreseeable, but under the circumstances, that qualifier seems to add little." (citation omitted)).

The requirement to prove in addition that their alleged increased risk creates a need for future medical monitoring will not deter many plaintiffs. Notwithstanding the wide agreement in the medical community that screening for latent disease in asymptomatic persons is generally not beneficial, *see supra* at 13-19, on this, as on other scientific issues that come to court, there are always experts who are willing to testify to fringe views for a fee. *Cf. Stoleson* v. *United States*, 708 F.2d 1217, 1222 (7th Cir. 1983) ("there is not much difficulty in finding a medical expert witness to testify to virtually any theory of medical causation short of the fantastic"). In one medical monitoring case, the plaintiffs produced an expert who testified that an expensive program of special medical monitoring is required for "anyone who lived near a toxic dump site . . . even if they lived three blocks away." *Paoli II*, 35 F.3d at 794. Another expert in that case opined that anyone who has been exposed to even one molecule of an allegedly hazardous substance should receive medical monitoring on account of such exposure. *Id.* The Third Circuit in that case held that such opinions were admissible under Rule 702 of the Federal Rules of Evidence and this Court's decision in *Daubert* v. *Merrell Dow Pharms., Inc.*, 509 U.S. 579 (1993), and were

sufficient for the plaintiffs' medical monitoring claims to survive summary judgment. *Paoli II*, 35 F.3d at 793-95.

With the evidentiary burden set so low, there is little to deter enormous numbers of medical monitoring claims. It has been suggested that a plaintiff is not likely to pursue such a claim unless "he or she thinks the [medical] tests are really needed." *Id.* at 788. But many courts, including the Court of Appeals in the present case, have not required that the recovery on medical monitoring claims in fact be used for medical testing. These courts refer to medical monitoring recovery as "damages." *Buckley*, 79 F.3d at 347; *Bocoock*, 819 F. Supp. at 536; *Potter*, 25 Cal. Rptr. 2d at 579; *Meyerhoff*, 534 N.W.2d at 206; *Askey*, 477 N.Y.S.2d at 247; *but see Burns*, 752 P.2d at 34 (medical monitoring recovery should take form of court-administered fund); *Ayers*, 525 A.2d at 313-15 ("encourag[ing]" use of a court-administered fund); *Hansen*, 858 P.2d at 982 (defendants should pay only for medical monitoring services actually provided to plaintiffs). "[D]amage awards do not restrict plaintiffs in the use of money paid as compensatory damages." *Ayers*, 525 A.2d at 314. What little empirical evidence is available suggests that plaintiffs who have received funds in settlement of medical monitoring claims in fact often have not used the money for medical testing. *See* George W.C. McCarter, *supra*, at 257 n.158.

One court has ventured that "the damages available in a medical monitoring claim—the cost of the tests—are not likely to be high enough to provoke a flood of litigation." *Paoli II*, 35 F.3d at 788. There is no basis for such an assumption. In one early case that was tried to judgment, 339 plaintiffs were awarded a total of $8.2 million for future medical monitoring—an average of about $25,000 per plaintiff. *Ayers*, 525 A.2d at 291. In the *Paoli* litigation itself, one of the plaintiffs' experts offered the opinion that the plaintiffs needed to undergo a wide variety of specialized evaluations and tests every

year for "at least 25 years," at a projected annual cost of at $3080 per plaintiff, or $77,000 per plaintiff over twenty-five years.[14] Possible recoveries of this magnitude are more than enough to attract litigants, especially since most courts do not demand highly individualized proof of medical monitoring claims, *see, e.g., Paoli II*, 35 F.3d at 788, making possible the aggregation of hundreds of such claims, *see, e.g., Ayers*, 525 A.2d at 287.

Some plaintiffs, like respondent, will be motivated to press medical monitoring claims largely by the desire to hold apparent wrongdoers "accountable for what they did." *Buckley*, 79 F.3d at 1341. Under traditional tort principles, an alleged wrongdoer could be called to answer in a negligence action only by someone who had sustained physical injury or severe emotional distress allegedly caused by the wrongdoing. The medical monitoring tort in effect confers standing on all persons in the vicinity of a toxic chemical to challenge, if they wish, the conduct of whomever they deem responsible for the presence of the chemical. One need not doubt the sincerity of most plaintiffs to predict that some will abuse that right.

B. Medical Monitoring Claims Are Inherently Speculative, and Threaten Defendants With Arbitrary and Unpredictable Liability.

Traditional tort-law notions of "injury" contain built-in protections against speculative claims. The physical injuries with which tort law has mostly concerned itself are normally susceptible to observation or some other form of objective confirmation. Emotional injuries, although not directly observable, have traditionally been compensated only in circumstances in which they are likely to yield some external corroboration of their existence. *See Atchison, Topeka & Santa Fe Ry. Co.* v. *Buell*, 480 U.S.

[14] *See* Medical Surveillance Program prepared by G. John DiGregorio, M.D., Ph.D., at 4, in *In re Paoli R.R. Yard PCB Litig.*, No. 86-2229 (E.D. Pa.).

557, 569 n.18 (1987). The medical monitoring tort provides no such check on speculative claims. The injury involved—a plaintiff's "need" for future medical testing—has no objective existence.

Courts that recognize the tort have opined that it will not engender speculative claims because plaintiffs must prove their need for future medical monitoring by competent expert testimony. *See, e.g., Paoli I*, 916 F.2d at 850-52; *Ayers*, 525 A.2d at 308-09. But the fact that a claim can be supported by competent expert testimony does not necessarily make it non-speculative.

For example, even courts that accept the medical monitoring tort agree that a claim for the "increased risk" of disease, as such, is too speculative to be allowed, even if competent experts can be found to support such a claim.[15] *E.g., Paoli I*, 916 F.2d at 850-51; *Potter*, 25 Cal. Rptr. 2d at 569 n.15; *Ayers*, 525 A.2d at 304-08. There is no basis for treating a medical monitoring claim any differently. Such a claim requires, as an essential element, proof that the plaintiff is at increased risk of future disease. The speculative character of such proof is not mitigated by requiring, in addition, expert proof of *other* matters. An opinion that a currently healthy plaintiff requires special future medical monitoring is inherently speculative because it necessarily rests on a speculative premise: the existence of some small possibility—perhaps as little as a one-in-a-million chance—that because of a chemical exposure the plaintiff might years in the future develop a disease that might benefit from early detection and treatment. That an expert can put a present-day price tag on the "need" for future medical monitoring to detect such disease does not remove the dominant element of speculation.

The dangers of speculation in medical monitoring claims are especially severe because the opinion that a

[15] An "increased risk" claim seeks recovery for the consequences of a future harm that may, but probably will not, come to pass. *See Bocook*, 819 F. Supp. at 536.

particular plaintiff needs future medical monitoring is not easily subjected to verification or falsification. The expert's opinion is neither an explanation of how scientific phenomena have occurred in the past nor a prediction of how they will probably occur in the future. Because the plaintiff is not currently sick, and will probably never develop any exposure-related illness, the expert has no responsibility to tie his opinion to objective reality. The opinion is pure say-so.

Given the ease with which plaintiffs can make out a triable claim for future medical monitoring, and the speculative nature of the claim, liability will be imposed on defendants, when it is imposed, in a random and unpredictable manner. The medical monitoring tort, like the open-ended version of the emotional-distress tort rejected in *Gottshall*, provides defendants with no meaningful "standard against which to regulate their conduct." *Gottshall*, 114 S. Ct. at 2409. The only standard set up by the medical monitoring tort is: do not negligently allow any chemical exposure that might cause an expert witness to say exposed persons need future medical testing to detect possible latent disease. That, as a practical matter, is no guidance at all. Nor is the bare standard that parties should not engage in negligent conduct enough to guide defendants and prevent arbitrary outcomes, any more than it was in *Gottshall*. *See id.*

C. There Is No Unfairness in Denying a Cause of Action for Medical Monitoring.

By comparison with the physical and emotional injuries that the law of negligence has traditionally compensated, the alleged need of currently healthy persons for special future medical testing has at best only a very weak claim on the limited resources of the judicial system. If one who has been exposed to a hazardous substance eventually does develop a disease that he believes was caused by the exposure, he is entitled (possible problems of claim-splitting aside) to pursue a conventional personal injury claim at that time. *See Simmons*, 674 A.2d at 239. But

when proof of such illness is lacking, there is no compelling reason why the legal system should entertain an exposed person's claim for future medical testing that the medical profession has widely concluded is ineffective, *see supra* at 13-19, and that the plaintiff may elect to forgo in any event, *see supra* at 25.

Moreover, the law should not create an entirely new tort, especially one guaranteed to spawn enormous litigation, where, as here, there is no evidence that the claimed injury cannot be remedied under existing social arrangements. Whereas traditional negligence claims compensate some forms of loss—pain and suffering, for example—that ordinarily cannot be insured against, the cost of medical testing is precisely the type of expense that health insurance is designed to cover. Approximately 85% of all Americans are covered by some form of health insurance. U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 120 (1996). Health insurance pays for about 80% of all standard medical bills. *See* 2 AMERICAN LAW INST., ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY—REPORTERS' STUDY 379 (1991). To the extent that persons exposed to hazardous substance may have a genuine need for medical testing to detect possible latent disease, most such testing will probably be covered by some form of health insurance.

> [T]here is no strong reason for devising a novel form of early tort intervention to pay for the modest uninsured expenses likely to be incurred by those who were exposed but are not yet diseased.

Id. Where health insurance coverage exists, the medical monitoring tort simply confers a windfall on plaintiffs who are not ill, and are unlikely ever to become ill, because of the defendant's conduct.[16]

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[16] On traditional tort claims, the law ignores the fact that the plaintiff has received insurance benefits from a "collateral source." 4 FOWLER V. HARPER, *supra*, § 25.22, at 651 n.7. *Friends for All Children*, 746 F.2d at 816, though not a true medical monitor-

CONCLUSION

For the reasons stated, the judgment should be reversed.

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ing case, *see supra* n.4, suggests that the collateral source rule should not apply when plaintiffs seek the cost of future medical testing. There the plaintiffs resided in several European countries, but the trial court awarded the costs of diagnostic testing only to the plaintiffs who resided in France, the only country involved where the public health service was not likely to pay for the testing sought. 746 F.2d at 822 n.7.